Spa Client Profile & Medical History

Date: _____/_____/___________

NAME: ______________________________ DOB: ____/____/____ AGE: ____ FEMA☐ M☐E

STREET ADDRESS: ____________________________________ CITY: _____________ STATE: ______ ZIP: _________

HOME PHONE: _____________________ CELL PHONE: _____________________ WK PHONE: ________________

EMAIL: ____

Please describe the reason for today's Consultation:____

How does the problem affect you? ____

What is important to you when deciding on treatment?____

Who can we thank for referring you?____

Please describe your skin & other cosmetic concerns by checking all that apply:

__ Acne	__ Droopy Eye Lids	__ Lip Lines	__ Scars	__ Thin Lips
__ Blackheads	__ Facial Redness	__ Menstrual Acne	__ Skin Discoloration	__ Under Eye Bags
__ Cellulite/Fat	__ Facial Veins	__ Oily Skin	__ Skin Tags	__ Under Eye Dark Circles
__ Double Chin	__ Large Pores	__ Pimples	__ Stretch Marks	__ Unwanted Hair
__ Dry Skin	__ Fine Lines/Wrinkles	__ Saggy Skin	__ Sun Damage	__ Whiteheads

Ethnicity: ☐ Caucasian ☐Asian ☐Hispanic ☐Mediterranean ☐ican American

List ALL Prescription & Over the Counter Medications You Are Currently Taking:
(Including: Accutane, Retin A)

1) ________________ 2) ________________ 3) ________________ 4) ________________ 5) ________________

Any chance of pregnancy YES ☐ NO ☐ Use of Antibiotics YES ☐ NO ☐

Tanning products, tanning bed or sun YES ☐ NO ☐

Medication Allergies:

____

Cosmetic Ingredient Sensitivity or Allergies (complete section in its entirety):

Vitamin C Topical ___Yes ___No
Vitamin E Topical ___Yes ___No
Benzoyl Peroxide ___Yes ___No
Retin A/Retinol ___Yes ___No

Hydroquinone ___Yes ___No
Sunscreen ___Yes ___No
Aloe Vera ___Yes ___No
Glycolic ___Yes ___No

Check Any of the Following Medical Conditions That Currently Apply:

___ Bleeding Disorder	___ Herpes	___ Hormone Imbalance	___ Menopausal	___ Seizure Disorder
___ Cancer	___ Heart Disease	___ Immune Disorder	___ Migraines	___ Thyroid Condition
___ Claustrophobia	___ Hepatitis	___ Keloid Scars	___ Neurological Disease	
___ Cold sores*	___ High Blood Pressure	___ Kidney Disease	___ Pregnancy/Nursing	
___ Diabetes	___ HIV	___ Lupus	___ Rosacea	___ *NONE*

Symptom ***(please check mark)***	**Never**	**Mild**	**Moderate**	**Severe**
Depressive mood (feeling down/sad/lack of drive)				
Memory Loss (forgetfulness)				
Mental confusion (feeling in a mental fog)				
Decreased sex drive/libido (decreased desire for sex)				
Sleep problems (difficulty falling/staying asleep/wake up tired)				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness Hot				
flashes				
Night sweats				
Dry and Wrinkled Skin				
Hair is Falling Out				
Cold all the time				
Swelling all over the body				
Joint pain				

Patient Signature: ______________________________ **Date___/___/___**

We accept Care Credit !

11970 N. Central Expy Suite 300 Dallas TX 75243